



LITTLE HOOVER COMMISSION

June 23, 2005

Michael E. Alpert
Chairman

Stanley R. Zax
Vice Chairman

David J. Epstein

Liz Figueroa
Senator

Daniel W. Hancock

Welton C. Mansfield

Eugene "Mitch" Mitchell

Stuart G. Moldaw

Pedro Nava
Assemblymember

Charles S. Poochigian
Senator

Leslie "Teddie" Ray

Joseph Rodota

Audra Strickland
Assemblymember

James P. Mayer
Executive Director

The Honorable Arnold Schwarzenegger
Governor of California

The Honorable Don Perata
President pro Tempore of the Senate
and members of the Senate

The Honorable Fabian Núñez
Speaker of the Assembly
and members of the Assembly

The Honorable Dick Ackerman
Senate Minority Leader

The Honorable Kevin McCarthy
Assembly Minority Leader

Dear Governor Schwarzenegger and members of the Legislature:

In the nearly four years since 9-11, California has made significant efforts to respond to the new range of threats. But are we prepared? State officials maintain that California is prepared, while a substantial number of local emergency officials assert that there is much more work to be done.

Policy-makers and the public deserve factual and validated responses to that question. But California has not put in place quantifiable means of benchmarking its capacities or measuring progress. One reason why the State may lack benchmarks is that California does not have the organizational structures – for public health or emergency response – that would provide for the necessary leadership and accountability.

It is clear that on a few key elements, the State has not made adequate progress. The State has not deployed a public health surveillance system that could detect serious threats in time to save thousands of lives. The State has not stopped the erosion of its laboratory capacity, which is essential to analyzing and informing medical responses. The State does not have a cohesive strategy for developing the surge capacity necessary to accommodate large numbers of injuries or illness. The State has not assessed the consequences of budget cuts that local officials say will thwart a coordinated response to regional disasters. And the State does not have in place a plan – or even a deadline for establishing a plan – to ensure that first responders from different agencies can communicate when they respond to the same disaster.

The concerns go beyond disasters to include the disastrous. Some 10,000 people die in California each year because of infections that they acquired in hospitals. California needs an evidence-based and data-driven strategy for reducing this threat.

On the following pages the Commission reiterates and refines recommendations that it has made over the last three years that should be considered priorities. The Commission urges your consideration of these issues.

Sincerely,

Michael E. Alpert
Chairman

Setting Priorities

In two previous reports, the Commission pointed out critical gaps in the State's public safety infrastructure. In a 2002 report titled, *Be Prepared: Getting Ready for New and Uncertain Dangers*, the Commission identified weaknesses in the State's preparedness in light of the threats revealed by the September 11 attacks. In 2003, the Commission examined in detail the weakest of those links in a report titled, *To Protect and Prevent: Rebuilding California's Public Health System*.

California is rightly proud of its abilities – developed through necessity – to respond to disasters. The terrorist attacks redefined both the nature of the threats facing California, as well as what must be done to respond to those threats. In no small irony, the Southern California firestorms of October 2003 once again demonstrated that given the State's continuing and expansive urban development, age-old and natural hazards can outmatch the systems intended to deploy and manage people and equipment to minimize damage and help the harmed.

In *Be Prepared*, the Commission recommended that California fortify its structure for governing emergencies, require risk and vulnerability assessments, and establish standards for readiness that are periodically reported to lawmakers. It recommended mechanisms to disseminate and replicate best practices across all jurisdictions, establishing priorities for expenditures and training, employing enhanced technologies, and improving public communications. It recommended measuring the adequacy of emergency medical capacity and ensuring needed resources are devoted to building public health capacity.

Recommendations for Emergency Preparedness and Public Health

In its follow up review of emergency preparedness and public health, the Commission found that several of its prior recommendations for improvements have not been made a priority. The Commission urges the Governor and the Legislature to prioritize the following recommendations:

1. *Enact legislation to establish the separate department of public health, with physician leadership and with advice and oversight of a scientific public health board.*
2. *Install a real-time surveillance system that can quickly detect the emergence of contagious disease, whether naturally occurring or the result of bioterrorism.*
3. *Require an independent and expert assessment of the State's public health laboratory and other essential capacities.*
4. *Develop an aggressive response to hospital-acquired infections. By December, the administration should propose a plan – endorsed by such independent experts as the deans of California's medical schools – that will reduce the illness and death resulting from these infections.*
5. *The administration should propose a strategy and a structure clarifying the roles and responsibilities of emergency-related agencies.*
6. *Lay out a plan for resolving electronic communication problems, including the funding needs and resource plan.*
7. *Exercise the regional capacity of the Office of Emergency Services to ensure that budget cuts have not diminished the capacity to respond to large -scale events.*

In *To Protect and Prevent*, the Commission concluded: “The State’s public health leadership and organizational structure is ill-prepared to fulfill the primary obligation of reducing injury and death from threats that individuals cannot control, such as environmental hazards, bioterrorism, and emerging infectious diseases.”

The Commission recommended structural reforms: a separate department of public health, lead by a Surgeon General, with advice and oversight by a scientifically expert board. It recommended fortifying the core functions, including laboratory capacity, and deploying 21st Century technology to immediately detect outbreaks. The Commission recommended the State “prioritize public health spending as one of the core components of public safety, equal to fire and police.”

Some concrete improvements deserve recognition. The administration has made preparedness a priority in senior appointments and has devoted additional resources to fortify well-known weaknesses. For instance, firefighting equipment is being bolstered and electronic reporting of reportable diseases is finally on track. Positions for bioterrorism preparedness that had been left vacant have been filled, and a state health officer from the senior ranks of CDC bioterrorism preparedness was brought in to lead the charge for building this capacity.

But the State also has had difficulty keeping some of these experts, and at least in the case of the public health officer, the inability to make needed changes was enough reason to leave state service.

This spring, the Commission revisited these issues to assess whether progress is being made. The administration was asked to provide written summaries of their activities. The Commission visited the state laboratory, and consulted with many of the experts and state and local officials who contributed to the previous projects.

The Commission conducted a public hearing in May 2005, soliciting testimony from federal, state and local officials. Witnesses included the directors of California Homeland Security, the Office of Emergency Services, the Emergency Medical Services Authority, the Department of Health Services, and the National Guard.

The Commission heard from two of the nation’s experts on bioterrorism preparedness, a lead physician for Kaiser on bioterrorism, the California Local Health Officers Association and the Public Health Association. The Commission heard from the chair of the Blue Ribbon Fire Commission, the retired commander of the Air National Guard Federal Task Force for wildfires, the California Association of Emergency Managers, CDF Firefighters and the California Association of Highway Patrolmen. Written testimony from these witnesses is on the Commission’s Web site.

According to that testimony, concrete progress has been made, but additional steps must be taken to prepare California for large-scale disasters. In this report, the Commission reiterates some of its earlier recommendations, which it believes should be made a priority.

Necessary Steps

Over the last two years, many of the Commission's recommendations have prompted significant debate, and in many cases broad-based support. But despite the strong case for reform, some of these improvements have not been made a priority. In reviewing the progress that has been made, many of the stakeholders validated the need to advance the following recommendations.

1. Enact legislation to establish the separate department of public health, with physician leadership and with advice and oversight of a scientific public health board.

The California Medical Association, the California Association of Public Laboratory Directors, the Health Officers Association of California and the Northern and Southern California public health associations all support the recommendation to focus the mostly scientific public health functions in a separate department.¹ These competencies are substantially different than the dominant mission of the Department of Health Services to administer the Medi-Cal program. The proposal is essentially cost neutral and has had bipartisan support in the Legislature.²

The administration advanced this reform by appointing a physician as state health officer, who started to unite and fortify the functions within DHS. But barely a year after taking on the job, the nationally recognized physician resigned, in part because of a lack of authority to use available resources to protect the public.³ A separate department is essential if the state health officer is to work with counties and the private sector to build a strong network of laboratory and other capacities.

The proposed board would provide expert oversight that would inform and validate the department's efforts and provide to the public and policy-makers the expert and independent analysis of the State's capacities.⁴

Leaders Call for Department and Board

Today the issues are more critical than in the past, due in part to the threat of bio-terrorism for which public health carries a substantial responsibility. California is especially vulnerable, and we depend on public health both to detect the existence of bio-terrorism (which may not be obvious) and to help mobilize resources to combat it. We have other new issues such as the possibility of Avian Flu, for which we are also especially vulnerable because of our location and ports; and the increase of diabetes; as well as many long-standing public health problems. ... The proposed separation of public health from the current Department of Health Services has been evaluated by practically everybody in the State competent in this matter.... All of them favor separation. The time has come for action to protect the health of Californians.

-- Lester Breslow, M.D., M.P.H., former California State Health Officer and president of the American Public Health Association; Professor & Emeritus Dean, UCLA School of Public Health. May 26, 2005.

Disappointed with the resignation of the State's health officer, a coalition of medical and public health leaders have requested that the governor "establish a separate Department or Center for Public Health with a State Health Officer reporting directly to [the Governor] and a broadly representative State Board of Health to advise and support the State Health Officer." They note that "the CDHS seems overwhelmingly preoccupied with the Medi-Cal program and other non-public health programs." -- California Medicine and Public Health Initiative coalition of the California Medical Association, public health associations and the physician health officers associations. June 14, 2005.

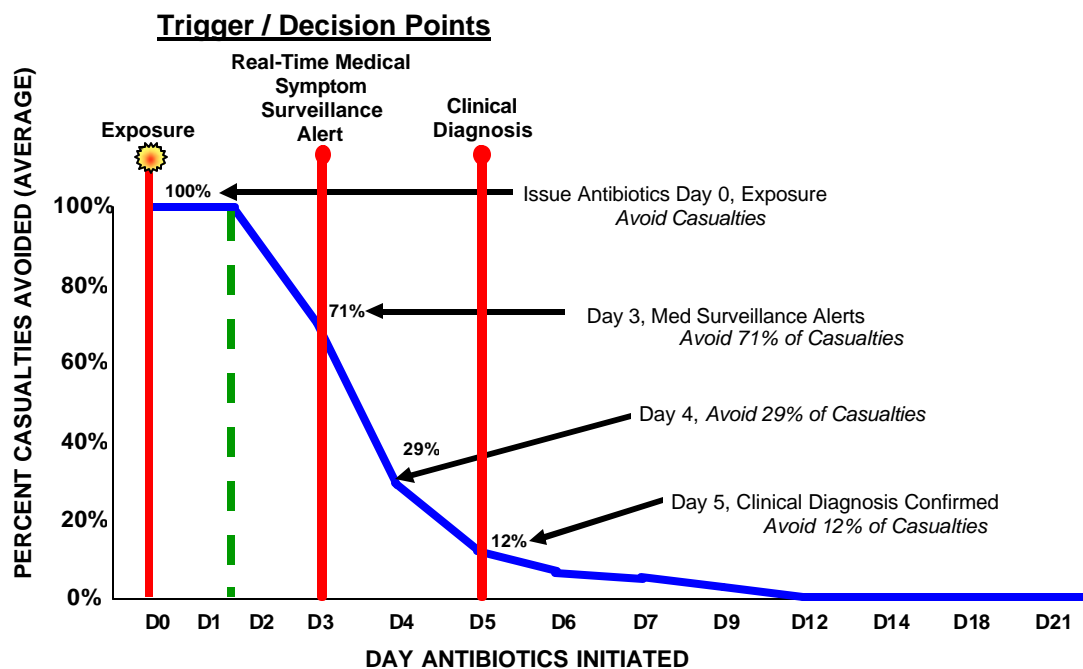
2. Install a real-time surveillance system that can quickly detect the emergence of contagious disease, whether naturally occurring or the result of bioterrorism.

One of the greatest challenges facing the public health system is the early detection of threats. In many instances, a quick response can save thousands of lives.⁵ Fortunately, new technologies are providing cost-effective ways to identify the symptoms of individual patients, providing for immediate detection and analysis of problems.

The State has made progress by developing a way for physicians to electronically report those diseases that must be reported by law, as well as a secure internet means to communicate with health providers and public health officials.⁶ But the former White House bioterrorism expert said that system will not detect outbreaks soon enough to significantly reduce illness and death.⁷ That official recommended that states embrace systems that detect and report symptoms, which allows health officials to identify significant threats long before diagnoses are completed and reported.

For example, the SYRIS system was collaboratively developed by former scientists and physicians in United Nations bio-weapons inspection programs and from Sandia National Labs. That system allows physicians to enter unusual symptoms to help formulate a diagnosis, and in turn that information helps officials to quickly identify diseases that are of concern. Texas has successfully tested the surveillance technology in 44 counties and is expanding the system. During the pilot project, the system detected an unusual influenza outbreak and dispelled a suspected bioterrorism threat.⁸ The chart below identifies the number of lives that can be saved by early detection of an outbreak using a real-time medical symptom surveillance system.

Early Detection is the Key



Source: Colonel Robert Kadlec, M.D., Staff Director, Subcommittee on Bioterrorism and Public Health, U.S. Senate. May 26, 2005. Written testimony to the Commission.

The system also was tested by Kaiser Permanente in San Mateo County.⁹ The health care provider, which is interested in expanding the system, has found it difficult without state leadership to persuade county officials to change the way they do business. The State could implement this technology for approximately \$5 million or 15 cents per Californian.¹⁰

Symptom Mapping & California Public Health Preparedness

Robert Kadlec, M.D., staff director, U.S. Senate Subcommittee on Public Health and Bioterrorism Preparedness, and former White House director of bio-defense:

The U.S. [is] lucky for not having experienced a large scale bio-attack given Al'Qaeda's intentions and capabilities....Early warning, surveillance and detection are not only vital for acts of bioterrorism, but acts of Mother Nature like SARS and Avian Influenza. ...Public health infrastructure is becoming more part of our national security infrastructure and I can tell you from the view of many in the U.S. Senate today, the importance of revitalizing the public health infrastructure, realizing that the center of gravity of that infrastructure has to be focused on surveillance and detection, is one of the priorities...

Alan Zelicoff, M.D., inventor of the SYRIS clinical symptom mapping system, author of "Microbe: Are We Ready for the Next Plague," former senior scientist, Sandia National Laboratory's Center for National Security and Arms Control and former member U.S. Delegation to the Biological Weapons Convention:

Billions of homeland security and counter-terrorism dollars have been squandered; there is no communication of actionable knowledge among public health officials, let alone to doctors, vets, and political decision-makers... As a society, we have the option to act intelligently and quickly to save lives without waiting for the next disaster to shake us out of our moribund, technologically aversive posture in public health. We can do better and negligence in the face of grave public danger simply must not be tolerated. ...bioterrorism preparedness... can be fixed for a song plus just a little effort on the part of caring, forward thinking public health officials.... Hours matter, days are too late.

Eric Koscove, M.D., Chief, Emergency Department, Kaiser Permanente Medical Center, Santa Clara and co-chair, Kaiser Permanente National Healthcare Continuity Management Committee, Assistant Professor, Stanford University Medical School:

Significant barriers identified in previous testimony remain in place. ...There is presently no cohesive statewide surveillance system which could, in a timely manner, alert public health authorities and practicing physicians of a bioterrorism event. If there were to be another outbreak of a new disease like SARS, or a terrorism attack using biological agents, California's medical and public health system is not prepared to detect the outbreak in a timely manner. ... the speed of awareness of a biological attack could mean the difference in hundreds of thousands of lives saved or lost.... Kaiser's ... pilot of an active Internet-based syndromic surveillance system ... demonstrated the feasibility...on a practical basis. In the face of busy practices, the extreme speed and ease of system use was critical ... we are eager to foster statewide collaboration with Public Health.

Source: Statements made in written testimony or during May 26, 2005 Commission hearing.

3. Require an independent and expert assessment of the State's public health laboratory and other essential capacities.

Even before the budget crisis, the State's capacity to detect and analyze public health threats had greatly eroded.¹¹ In the aftermath of the terrorist attacks, and with federal assistance, some of the State's capacities have improved. However, staffing at the state's laboratory has continued to decline and laboratory officials report that they continue to lose ground in their struggle to hire, develop and retain a competent staff. The chart displays this trend.

***Department of Health Services Scientific Classifications
Related to Public Health Preparedness***

Division Scientists, Physicians & Nurses	2000- 2001	2001- 2002	2002- 2003	2003- 2004	2004- 2005	2005- 2006	Percent Change
Environmental & Occupational Disease Control	85.4	77.4	76.9	71.8	67.5	66.5	-22%
Communicable Disease Control	118.5	114.5	128.0	130.3	131.5	129.5	9%
Drinking Water & Environmental Management	183.0	178.5	174.1	180.9	166.5	175.0	-4%
Food, Drug & Radiation Safety	135.5	124.5	117.0	115.8	105.0	105.0	-22%
Health Information & Strategic Planning	45.0	45.0	48.0	42.0	36.0	36.0	-20%
Laboratory Science	83.5	88.0	79.0	59.2	60.0	65.0	-22%
Licensing & Certification	388.5	364.5	382.5	377.0	346.0	345.5	-11%

Source: California Department of Health Services. May 25, 2005. Written testimony submitted to the Commission. The 2005-06 numbers include 48 limited term federally funded positions.

Staffing alone is an inadequate measure of capacity, and the State's capacity needs to be assessed in the context of the services that local and federal labs can provide. If the State had an expert public health board it would have the means to provide the expert and independent analysis that would tell policy-makers and the public whether the State's capacity is adequate and what additional changes are warranted. Until a board is created, the Governor and the Legislature should secure another means for acquiring that assessment.

4. Develop an aggressive response to hospital-acquired infections. By December, the administration should propose a plan – endorsed by such independent experts as the deans of California’s medical schools – that will reduce the illness and death resulting from these infections.

The nation is facing an epidemic of hospital-acquired infections. The director of the Department of Health Services is reluctant to estimate, but officials within the department confirm that it is reasonable to estimate that 10,000 Californians die each year because of infections contracted within a health facility.¹² These largely preventable infections kill more Californians than any other infectious disease, including AIDs.¹³

The state has tremendous regulatory authority, and even greater capacity to educate providers, health insurers, patients and the general public on how this threat can be diminished. The issue is not insurmountable. Other states, such as Virginia, and other countries, such as Denmark, have worked aggressively to reduce these infections.¹⁴

The director said the department is creating a task force to examine that issue. The work of that group must be assertive, public and presented directly to the Governor and the Legislature for consideration.

While this is a threat that predates 9-11, it is possible that solutions to this problem can be integrated into those efforts that are being paid for with federal bioterrorism funds. In the event of the outbreak of a new disease or bioterrorism incident involving infectious agents, fewer fatalities would be expected if providers were already adhering to established methods to stop the spread of infections.

“If these [Little Hoover Commission 2003] recommendations for active surveillance cultures of patients and implementation of contact isolation were implemented today in all California healthcare facilities, many, many lives would be saved and healthcare costs would be reduced. We would be turning the tide on antimicrobial-resistant pathogens.”

William R. Jarvis, M.D.; Former director of Extramural Research; Center for Infectious Diseases, Centers for Disease Control and Prevention, Editor, Journal of Infection Control and Hospital Epidemiology of the Society for Healthcare Epidemiology of America

Preparedness Through Infection Control

Regarding nosocomial (hospital- acquired) infections and Bioterrorism, this is yet another example of how a robust epidemiologic detection/ surveillance/investigation system can have "dual use" to reduce the morbidity and mortality in conventional situations. In a BT or emerging disease event the largest risk for hospital-acquired and disseminated infections is during the period when the disease is unrecognized and/or unsuspected (e.g. early in the SARS outbreak in 2004). A robust detection/investigation system should reduce further the probability and duration of this period. One could imagine a similar system; coupled with a hospital- based, standardized database that would allow for investigation of "unusual hospital outbreaks" unrelated to BT or emerging diseases. While it is generally accepted that comprehensive hand washing by the entire health care team before and after patient care would significantly reduce nosocomial infections, these BT detection/ investigation systems and principles could also play a role in reduction of hospital- acquired infections."

Source: Steven Tharratt, M.D., M.P.V.M., Professor of Medicine, University of California, Davis, Medical Director, Sacramento County Emergency Medical Services; and Medical Consultant, California Emergency Medical Services Authority, written communication, June 2005.

5. The administration should propose a strategy and a structure clarifying the roles and responsibilities of emergency-related agencies.

The Commission in 2002 and again in 2003 recommended improving the chain of command and addressing the dysfunction of diffused responsibility. But drills – as well as actual emergencies, such as the San Diego fires – have shown that the chain of command is not clear, particularly as it relates to the involvement of federal agencies.¹⁵

In terms of medical readiness, the authority of the state's public health officer is particularly unclear, especially given the role of the Emergency Medical Services Authority. While the State has been required by the federal government to develop "surge capacity," responsibility for the planning has shifted among the agencies. And again while improvements have been made, the State does not have a definitive plan with established benchmarks that would tell the public or policy-makers whether this planning is adequate and what more needs to be done.

The State also has not reconciled or put into statute the role of the Office of Homeland Security, particularly as it relates to the Office of Emergency Services.

While senior administration officials say the chain of command is clear, local officials say there is confusion over the roles of OES and OHS and which agency is in charge. The California Emergency Services Association, which is comprised of local emergency response managers, recommends that the Office of Homeland Security be established as a unit within OES.¹⁶

OES has been lauded as a rational model because it has successfully coordinated responses among agencies that usually operate independently, evolving the Incident Command System and the State Emergency Management System. Some have suggested that OHS could complement that strength by taking on a planning and advising role, rather than solely a role in operations.

The Governor's May Budget Revision indicates the administration is ready to put OHS into statute, but the Commission has not had a chance to review that material.

Call to Action for Building Public Safety Capacity

U.S. Senate Leader Bill Frist, M.D., stated in June 2005 that the potential for biological attack, or an attack on the U.S. food supply, is very real, and that naturally evolving diseases are growing into such threats that he is proposing a "Manhattan Project for the 21st Century," to include establishing an effective, real-time foreign biological threat detection system. In his words, "failing to make it so could risk the life of the nation."

Jonathan Fielding, M.D., M.P.H., Health Officer, County of Los Angeles states two main concerns: "information technology capacities for real time management of a public health emergency, and critical staffing issues."

Sources: U.S. Senator Bill Frist, M.D., June 1, 2005. Speech to Harvard Medical School, New York Times http://frist.senate.gov/_files/060105manhattan.pdf. Web site accessed June 15, 2005. Jonathan Fielding, M.D., M.P.H. May 25, 2005. Letter to the Commission.

Policy-makers also might want to consider reactivating the Emergency Council, which was designed to coordinate state assets during emergencies.¹⁷ Senior officials say the Governor intends to make appointments to the council, which last met in July 2002.

Whatever its strengths and weaknesses, the structure has been further challenged by instability among the leadership. In the last month, both the state health officer and the adjutant general of the National Guard have resigned. The state has had four directors of Homeland Security in as many years, and the director of the Emergency Medical Services Authority, who has served in an “acting capacity” for eight years, is expected to resign.

6. Lay out a plan for resolving electronic communication problems, including the funding needs and resource plan.

The State has made substantial progress enlisting and preparing volunteers. First responders have undergone specialized training, and progress has been made in conducting practice exercises by OES and the National Guard. However, the State still lacks critical standards to ensure that all responders are prepared to serve together and will be able to communicate effectively when called up to respond.

Due to the sheer scale of the Southern California firestorms, management, equipment and communications were all stretched as more than 1,000 firefighting teams converged on the region. That disaster also revealed again the serious challenges of associated “radio interoperability.” The scale of the emergency brought so many emergency teams into the region that the radio system was overwhelmed.¹⁸

Local and state policy-makers – as well as the communication experts and the responders who rely on them – appear to be increasingly frustrated by the slow progress toward ensuring that multiple agencies can communicate during large-scale events.

“I would urge maximum utilization of the most advanced technologies we can acquire... on an urgent ‘wartime mentality’ basis.”

Brigadier General (Ret.) John Iffland, U.S. National Guard and Air Wing Commander, Federal Task Force – Wildfires

California has purchased a limited supply of expensive “black box” switching equipment, which was developed after 9-11 to improve interoperability. But those devices are expensive and have their own limitations. Officials also stress that how communication equipment is used can reduce the confusion caused by multiple responders, and so OES is expanding its training efforts. OES officials who are working on this problem cite a number of specific challenges.

- There is no simple, inexpensive way to upgrade the system.
- To completely modernize the system, cost estimates range from \$3.5 billion to \$5 billion.
- The technology is rapidly evolving, which is resulting in lower prices and higher functionality, which complicates decisions about which solutions to pursue when.

- Some solutions require uniformity among local government purchases, but the State is reluctant to limit local control over equipment decisions.
- Since there is no perfect system, picking one vendor is risky and further diminishes local control.

Still, the State has two separate committees – the California Statewide Interoperability Executive Committee and the Public Safety Radio Strategic Planning Committee – and neither committee has a clear charge and a deadline to provide policy-makers with the information they need to make wise choices about when and how to invest in needed upgrades. While the technical problems are challenging – and the solution may be expensive – policy-makers and the public deserve to know the State’s options and to benefit from the expertise of officials within OES who have been working on this problem.

7. Exercise the regional capacity of the Office of Emergency Services to ensure that budget cuts have not diminished the capacity to respond to large -scale events.

Local emergency response coordinators are concerned that the regional links of the California Statewide Emergency Management System (SEMS) have eroded and regional planning has fallen off the radar screen. This capacity is important because regional response plans kick in when events become too large for local officials to manage. Staffing at OES has been reduced from a peak of 938 in 1996-97 to 512 today, while OES has taken on the duties of the defunct Office of Criminal Justice Planning. During that same period, staffing at the regional offices has declined from 62 to 40.¹⁹

The workload at OES fluctuates with the size of recent disasters, because much of the staff is responsible for administering relief efforts. As a result, it is difficult to assess whether these reductions have impacted the ability to respond to disasters. OES staff in regional offices, as well as their counterparts in local communities, are concerned that response capacity has been diminished. One way to assess preparedness would be to conduct exercises designed to test regional response.

These exercises also should probe the incorporation of federal resources. In California’s most recent large-scale disasters, the 2003 Southern California fires, one problem was quickly drawing in federal firefighting assets.²⁰ Honing this capacity may be assisted through drills such as the federal TOPOFF exercises designed to involve federal, regional and state officials. During the April 20, 2005 hearing before the Homeland Security Subcommittee of the House Appropriations Committee, U.S. Senator Judd Gregg (R-NH), chair of the Homeland Security Subcommittee, questioned why California had not participated in one of the federal exercises: “I would hope that the department would take a look at whether or not we shouldn’t do them (TOPOFF exercises) to some degree based on threat criteria versus just the willingness of a Governor to participate or a state to participate.”

California has not volunteered to participate in a federal TOPOFF exercise, but has instead, relied on the exercise program run by the National Guard and OES, which some argue is more cost effective and better targeted to local needs. However, a TOPOFF drill may be useful if federal exercises are needed to test international incidents and cooperation.

Regional SEMS Weak Link?

I have grave concerns about regional preparedness and response capabilities in California. I believe that the statewide collection of emergency management programs is in danger of failing. I fear that all of the considerable efforts underway in local agencies throughout the state may well be in vain without the State of California's full commitment to its role in emergency management. The majority of issues outlined in your Commission's reports of 2002 regarding public safety remain unresolved... At the present level of effort, I believe that SEMS will fail at the regional level.

Source: Christopher Godley, Marin County Emergency Services Manager, presenting on behalf of the California Emergency Services Association. May 26, 2005. Written testimony to the Commission.

Conclusion

Over the last four years, state and local agencies have had to plan and prepare for new threats, while continuing to respond to the natural disasters that California is famous for. Those same officials have had to develop relationships with new partners, such as public health officials, and new agencies, including state and federal homeland security agencies. They have had to bolster their preparedness during difficult fiscal times for state and local agencies, but with an influx of federal money that had to be spent quickly, but in certain ways.

The Commission acknowledges those efforts and appreciates consideration given to its previous recommendations. It also believes that some of those previous recommendations – in terms of planning, organizational structure, and new technology – deserve additional consideration.

While there will always be more to do, Californians must be confident that government is adequately prepared. Many of the Commission's recommendations would provide a means for the public and policy-makers to validate that government agencies have met this standard.

***Witnesses Appearing at Little Hoover Commission Public Hearing
Emergency Preparedness Review – May 26, 2005***

Peter Abbott, M.D., M.P.H., President
California Public Health Association – North

Matthew Bettenhausen
Director, Office of Homeland Security
Office of the Governor

Richard Burton, M.D., M.P.H.
Placer County Health Officer
Director, Health & Human Services

Senator Bill Campbell
Chair, Governor's Blue Ribbon Fire Commission

Major General Thomas W. Eres
Adjutant General
California National Guard

Christopher A. Godley
Emergency Services Manager
Marin County Sheriff's Office of Emergency
Services

Jon H. Hamm, Chief Executive Officer
California Association of Highway Patrolmen

Brigadier General (Retired) John E. Iffland
U.S. National Guard and Air Wing Commander
Federal Task Force – Wildfires

Colonel Robert P. Kadlec, M.D.
Staff Director, Subcommittee on Bioterrorism
and Public Health, U.S. Senate

Eric M. Koscove, M.D.
Chief, Emergency Department
Kaiser Permanente Medical Center
and bioterrorism lead, Kaiser National
Healthcare Continuity Management
Committee

Henry R. Renteria
Director, Governor's Office of Emergency
Services

Jim Rissmiller
Legislative Director, CDF Firefighters
and Battalion Chief, San Bernardino County

Sandra Shewry, Director
California Department of Health Services

Stephen Waterman M.D., M.P.H.
Quarantine Medical Officer and
U.S.-Mexico Border Infectious Disease
Coordinator
U.S. Centers for Disease Control

Richard Watson, Interim Director
Emergency Medical Services Authority

Alan P. Zelicoff, M.D.
Senior Scientific Consultant, ARES Corporation
and former Senior Scientist, Center for Arms
Control and National Security, Sandia
National Laboratories

On the Web

The Commission's report regarding public safety concerns that require fortifying the scientific public health system, *To Protect and Prevent: Rebuilding California's Public Health System*, may be found on the following link:

<http://www.lhc.ca.gov/lhcdir/report170.html>

The Commission's report on all hazards preparedness, *Be Prepared: Getting Ready for New and Uncertain Dangers*, is linked here:

<http://www.lhc.ca.gov/lhcdir/report162.html>

Testimony from the Little Hoover Commission's hearing on May 26, 2005 regarding improvements and outstanding issues in preparedness:

<http://www.lhc.ca.gov/lhcdir/May05.html>

The Commission's June 2005 letter to the Governor and the Legislature:

<http://www.lhc.ca.gov/lhcdir/report170a.html>

Notes

1. California Medicine and Public Health Initiative letter, June 14, 2005, co-signed by presidents of the California Medical Association, the California Conference of Local Health Officers, and the public health associations, called for separate public health entity reporting directly to the governor, supported by a public health board and directed by a state health officer. April 2003 statements from chief executive officer, California Medical Association, president, California Public Health Laboratory Directors, and president, Health Officers Association of California.
2. Department of Finance staff, 2003, meeting with Commission staff. Co-authors have been from both parties.
3. Richard J. Jackson, M.D., State Health Officer, Medicine and Public Health Meeting discussion June 10, 2005.
4. As of 2003, 30 states had public health boards for this function according to "Nationwide Survey of State Boards of Health," December 2003, Washington State Public Health Board, accessed June 20, 2005 on http://www.doh.wa.gov/sboh/Pubs/StateBoardsReport_Final.pdf. California's public health board (1870 to 1970) oversaw the building of one of the strongest scientific public health departments in history.
5. Alan P. Zelicoff, M.D., "Microbe: Are We Ready for the Next Plague?" New York, New York, June 2005.
6. Richard J. Burton, M.D., Stephen Waterman, M.D., M.P.H., Peter Abbott, M.D., May 26, 2005, testimony.
7. Robert Kadlec, M.D., May 26, 2005, testimony and written communication.
8. Alan P. Zelicoff, M.D., May 26, 2005, testimony. Also, "Experience With Syndrome Based Electronic Surveillance in Lubbock, Texas, 1999-Present," Tigi Ward, B.S.N., M.S., City of Lubbock Health Department; Tommy Camden, MS, RS, Health Director, City of Lubbock Health Department; Tommy Camden, M.S., R.S., health director, City of Lubbock Health Department, 2005.
<http://www.lhc.ca.gov/lhcdir/emergprep/Zelicoffsupplemental.pdf>
9. Eric Koscove, M.D., May 26, 2005, testimony, and June 18, 2005 direct communication regarding piloting early version (Rapid Syndrome Validation Project).
10. Alan Zelicoff, M.D., May 26, 2005, testimony, and confirmatory email, June 2005.
11. Sandra Tougaw, President, California Public Health Laboratory Directors, and director, Sacramento County Public Health Laboratory, direct communication, June 6, 2005. Carmen Nevarez, M.D., M.P.H., medical director and VP of External Relations, Public Health Institute, letter to Commission, May 5, 2005.
12. DHS letter to the Commission June 6, 2005 states that the Centers for Disease Control estimates 90,000 people die from hospital acquired infections nationally each year. This number is cited in "Guidance on Public Reporting of Healthcare-Associated Infections," recommendations of CDC's Healthcare Infection Control Practices Advisory Committee, February, 28, 2005, which states that in 2003 there were approximately 2 million infections and 90,000 deaths from infections acquired in hospitals alone. In 2003, California accounted for 12.3 percent of the U.S. population, suggesting some 11,070 Californians are estimated to have died from hospital acquired infections that year. With population growth and no measurable improvements in hospital acquired infection rates or outcomes since that time, it is conservative to estimate that more than 10,000 Californians die annually from this cause. However, hospitals are not required

to report these infections. Experts confirmed estimate by direct communication, June 2005.

13. Because hospital acquired infections are only voluntarily reported to CDC, they are not listed in official national ranking tables for deaths from reportable diseases. National Center for Health Statistics, Health, United States, 2004, Chart Book on Trends in the Health of Americans, Hyattsville, Maryland, 2004, Table 52 indicates 42,478 Americans died of AIDS in 2002, and table 31 indicates 65,681 died from influenza and pneumonia, the number 1 listed *reportable* infectious disease category.
14. Little Hoover Commission, April 2003, "To Protect and Prevent, Rebuilding California's Public Health System," pp. 56-59. Also, Virginia's hospital acquired infections law is noted for its simple, yet effective approach by infection control experts. Specifically, Virginia amended its law to require reporting to their Board of Health and CDC, as follows: "Information on nosocomial infections. Acute care hospitals shall report information about nosocomial infections to the Centers for Disease Control and Prevention's National Healthcare Safety Network. Such hospitals shall release their infection data to the Board of Health. The specific infections to be reported, the hospitals required to report, and patient populations to be included shall be prescribed by Board regulation. Such hospital infection rate data may be released to the public by the Board, upon request." All provisions will be in effect by July 1, 2008.
15. Governor's Blue Ribbon Fire Commission, 2004, findings 1-1, 1-8, 2-5. Brigadier General John Iffland (retired), U.S. National Guard and Air Wing Commander, Federal Task Force, Wildfires, May 26, 2005, testimony to the Commission.
16. Resolution # 2004-01, California Emergency Services Association. Christopher Godley, May 26, 2005, testimony to the Commission.
17. Government Code Sections 8575-8582; 8600, 8610.
18. Governor's Blue Ribbon Fire Commission, 2004. Direct communications with OES staff, spring 2005.
19. Henry Renteria, director, Governor's Office of Emergency Services, May 26, 2005, testimony to the Commission.
20. Brigadier General John Iffland (retired), May 26, 2005, testimony to the Commission.

Complete titles for all May 26, 2005 hearing witnesses are listed on page 12. All testimony submitted electronically is available on the Commission's Web site at <http://www.lhc.ca.gov/lhcdir/May05.html>.